Tus neeg mob lub npe *Patient name*			
MHN *MHN*	Hnub yug *DOB*	Muaj tsawg xyoo *Age*	Poj niam los txiv neej *Gender*

Daim Ntawv Tso Cai Saib Cov ntaub Ntawv

Sharing of Information Authorization

A

Tus neeg mob
Patient

Lub xeem yav tas los – yog tias muaj *(Previous last name – if any)*		Tus xov tooj thaum nruab hnub *(Daytime phone number)*
Qhov chaw nyob *(Address)*		
Nroog *(City)*	Xeev *(State)*	Zauv Cheeb Tsam *(ZIP)*

B

Leej twg thiab muaj cov ntaub ntwv uas tsawb tau
Who has the information that is to be disclosed

☐ Marshfield Clinic Health System/Family Health Center
1000 North Oak Avenue, Marshfield, WI 54449 Phone: 1-800-782-8581, ext. 7-5687

☐ Lwm yam *(Other)* _____

Qhov chaw nyob *(Address)* _____

Nroog *(City)* _____ Xeev *(State)* _____ Zauv Cheeb Tsam *(ZIP)* _____

Tus xov tooj *(Phone number)* _____ Tus xov tooj xa ntawv *(Fax)* _____

C

Cov ntaub ntawv muaj rau tau tus twg saib
To whom the information should be disclosed

Lub npe *(Name)*	Tus xov tooj *(Phone number)*	
Txog rau *(Attention)*	Tus xov tooj xa ntawv *(Fax)*	
Qhov chaw nyob *(Address)*		
Nroog *(City)*	Xeev *(State)*	Zauv Cheeb Tsam *(ZIP)*

D

Cov ntaub ntawv kho mob lossis lwm cov ntaub ntawv uas yuav muab qhia tau rau cov txheeb ze lossis lwm tus neeg
Kos (✓) lub (cov) thawv uas qhia txog cov ntaub ntawv uas koj xav kom sib qhia

Medical or other information to be shared with relatives or other persons
Check (✓) box(es) to indicate the information you want shared

☐ Cov ntaub ntawv kho mob uas yuav qhia tawm tau: cov ntawv sau sib txuas lus los sis cov kev sib tham, kev tso lus cia, daim ntawv xyuas tias muaj sij hawm teem tau cia tiag (tsis suav cov kev kho txoj kev noj qab nyob zoo ntawm kev xav, kev kho AODA, qhov ntsuam xyuas tau los ntawm qhov soj ntsuam txog HIV)
Medical treatment information can be disclosed: written or verbal communication, voice mail, appointment verification (excluding mental health treatment, AODA treatment, HIV test results)

Xai cov hauv qab hauv no ua pom zoo tso cais rau qhia:
Check individual items below that can be shared:

☐ Cov ntaub ntawv qhia txog txoj kev kho txoj kev noj qab nyob huv online
Mental health treatment notes

☐ Kev kho txog kev quav dej cawv thiab lwm cov tshuaj
Alcohol and other drug therapy

☐ Cov ntawv sau txog kev kho mob
Neuropsychology notes

☐ Kuv tus naj npawb kuaj mob
My medical history number

☐ Kuaj kaus hniav
Dental

☐ My Marshfield Clinic – kev tswj txoj kev noj qab haus huv online
My Marshfield Clinic – online health management

☐ Kev kho HIV/AIDS, nrog rau qhov ntsuam xyuas tau
Treatment of HIV/AIDS, including test results

☐ Kev tso cais tsawb txog cov ntawv kho mob (muaj feem tau kev tso cais los ntawm kuv rau lwm lub tuam txab tuaj tsawb txog cov ntaub ntawv kho mob)
Authorize release of my medical records (which may include authorizing release of medical records to other facilities on my behalf)

☐ Tshawb fawb
Research

Txuas mus *(Continued)*

Tsab Ntawv Tso Cai Qhia Tawm Cov Ntaub Ntawv (Txuas mus)

Tus neeg mob lub npe *Patient name*	MHN *MHN*	Hnub yug *DOB*	Muaj tsawg xyoo *Age*	Poj niam los sis txiv neej *Gender*

D

Txuas mus
Continued

☐ Cov ntaub ntawv txog cov nqi hauv kuv tus as kauj uas tej zaum yuav muaj cov lus qhia txog txoj kev noj qab haus huv
Billing information about my account which may include health information

☐ Kws kho mob hauv Marshfield Clinic Health System (xws li kuv tus txiv, txiv thiab niam,me tub menyuam) muaj cai nkag mus saib tau kuv cov ntaub ntawv kho mob raws hluav taws xov (EMR)
Physician at Marshfield Clinic Health System (e.g. my spouse, parent, child) can access my electronic medical record (EMR)

☐ Cov ntaub ntawv raws li nram qab no: Ntsuam xyuas tau tias tus mob yog _____
Specific information as follows: Diagnosis

Tus neeg muab kev pab *(Provider)* _____

Lub sij hawm thaum *(Date range)* _____

E

Tas sij hawm
Kos (✓) lub thawv los qhia txog hnub tas sij hawm raws li qhov kev thov no

Expiration
Check (✓) box to indicate the expiration per this request

Kuv yog ib tug neeg tsis tau muaj hnub nyoog thiab kuv tau txais kev kho mob uas yuav tsum muaj los sis cia kuv tso cai qhia tawm cov ntaub ntawv kho mob no rau kuv niam kuv txiv los sis lwm tus neeg.
I am a minor and I have received medical care that requires or allows me to consent to the release of medical records of this care to my parents or any one else.

Kos (✓) cov thawv ntawm cov ntaub ntawv kho mob uas yuav qhia tawm:
Check (✓) boxes of medical records to be disclosed:

☐ Txiav dej caw los yog txiav lwm yam yaj yeeb (12 xyoos rov sauv) (niam thiab txiv yuav tsum tau kos npe hauv qab no)
Outpatient alcohol or other drug dependency care (12 years or older) (parent may also be required to sign below)

☐ Txiav dej caw los yog txiav lwm yam yaj yeeb – mus nyob kom zoo cawv xwb (12 xyoos rov sauv) (niam thiab txiv yuav tsum tau kos npe hauv qab no)
Inpatient alcohol or other drug dependency care – detoxification only (12 years or older) (parent may also be required to sign below)

☐ Kev mos deev los yog raug mos deev/quab yuam (12 xyoos rov sauv) (niam thiab txiv yuav tsum tau kos npe hauv qab no)
Rape or sexual assault/abuse (12 years or older) (parent may also be required to sign below)

☐ Kev pab rau txoj kev noj qab nyob zoo ntawm kev xav uas tsis tau pw tim tsev kho mob (14 xyoos los sis rov saud)
Outpatient mental health care (14 years or older)

☐ Kev pab rau txoj kev noj qab nyob zoo ntawm kev xav uas tau pw tim tsev kho mob (14 xyoos los sis rov saud)
Inpatient mental health care (14 years or older)

☐ Ntaub ntawv kuaj hlwb (14 xyoo rov sauv) (niam thiab txiv yuav tsum tau kos npe hauv qab no)
Neuropsychology notes (14 years or older) (parent may also be required to sign below)

☐ Cov kev ntsuam xyuas tau txog HIV/AIDS (14 xyoos los sis rov saud)
HIV/AIDS test results (14 years or older)

☐ Kab mob kis thaum sib deev (17 xyoo los sis yau dua)
Sexually transmitted disease (17 years or younger)

☐ Kuaj saib cev puas xeeb tub (17 xyoo rov hauv) (niam thiab txiv yuav tsum tau kos npe hauv qab no)
Pregnancy test (17 years or younger) (parent may also be required to sign below)

Txuas mus *(Continued)*

Tsab Ntawv Tso Cai Qhia Tawm Cov Ntaub Ntawv (Txuas mus)

Tus neeg mob lub npe *Patient name*	MHN *MHN*	Hnub yug *DOB*	Muaj tsawg xyoo *Age*	Poj niam los sis txiv neej *Gender*

E

Txuas mus
Continued

☐ Tshuaj caiv menyuam los yog lwm yam (17 xyoo rov hauv) (niam thiab txiv yuav tsum tau kos npe hauv qab no)
Birth control pills or devices (17 years or younger) (parent may also be required to sign below)

☐ Kev kho mob thaum cev xeeb tub los sis kev pab tus me nyuam mos (17 xyoo los sis yau dua)
Pregnancy-related care or care of newborn (17 years or younger)

☐ Kws kho mob hauv Marshfield Clinic Health System (xws li kuv tus txiv, txiv thiab niam,me tub menyuam) muaj cai nkag mus saib tau kuv cov ntaub ntawv kho mob raws hluav taws xov (EMR) tag nrho tabsi tsis txwv cov ntaub ntawv saum no (niam thiab txiv yuav tsum tau kos npe hauv qab no)
Physician at Marshfield Clinic Health System (e.g. my spouse, parent, child) can access my electronic medical record (EMR) including but not limited to information above (parent may also be required to sign below)

_____ _____ /_____ /_____
Tus neeg mob kos npe
Patient signature
Hnub tim (hli/hnub tim/xyoo)
Date (m/d/y)

F

Tas sij hawm
Kos (✓) lub thawv los qhia txog hnub tas sij hawm raws li qhov kev thov no

Expiration
Check (✓) box to indicate the expiration per this request

Tsab ntawv tso cai no yuav siv twj ywm:
This authorization will remain in effect:

☐ Thaum hnub tim kos npe rau
tsab ntawv tso cai no mus txog rau thaum _____ hnub _____ , *20* _____
From the date this authorization is signed until the # day of (month/year)

☐ Kom txog thaum koj sau ntawv kom tshem tawm qhov kev tso cai no
Until you cancel this authorization in writing

☐ Kom txog thaum cov nram qab no tshwm sim,
qhia seb qhov ntawd yog dab tsi _____
Until the following event occurs, specify event

☐ Lwm yam, qhia seb yog dab tsi _____
Other, specify

G

Thaum kos npe rau qhov no, koj tso cai rau kev siv thiab qhia tawm cov ntaub ntawv uas koj tau xaiv saud. Koj lees tias koj tau soj ntsuam thiab nkag siab txog tsab ntawv tso cai no, nrog rau cov lus tshaj tawm hauv qab no.
By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form, including the notices below.

_____	_____	_____ /_____ /_____	_____
Tus neeg mob kos npe (Tus neeg mob tus neeg sawv cev raws txoj cai) *Patient signature (Patient's legal representative)*	(Kev sib txeeb rau tus neeg mob) *(Relationship to patient)*	Kos npe hnub tim (hli/hnub tim/xyoo) *Signature date (m/d/y)*	Tus xov tooj *Phone number*

Xa daim ntawv tso cais uas teb tag mus rau: Health Information management, HM2, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-389-0564 E-mail: himspec@marshfieldclinic.org
Send completed authorization to: Health Information Management, HM2, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449 Fax: 715-389-0564 E-mail: himspec@marshfieldclinic.org

Tsab Ntawv Tso Cai Qhia Tawm Cov Ntaub Ntawv (Txuas mus)

Tus neeg mob lub npe *Patient name*	MHN *MHN*	Hnub yug *DOB*	Muaj tsawg xyoo *Age*	Poj niam los sis txiv neej *Gender*

Lus tshaj tawm rau tus neeg mob txog kev rov qab muab qhia tawm: Yog hais tias tus (cov) neeg thiab/los sis lub (cov) koom haum uas muaj npe nyob rau sab ua ntej no tsis yog cov neeg muab kev pab kho mob, cov koom haum muab kev pab kho mob, los npaj rau kev noj qab nyob zoo, cov ntawv qhia txog kev kho mob uas qhia tawm los ntawm qhov koj tso cai tej zaum yuav tsis muaj kev tiv thaiv mus ntxiv los ntawm Tsoom Fwv cov qauv txog qhov tsis pub lwm tus neeg paub yog hais tias tus (cov) neeg thiab/los sis lub (cov) koom haum rov qhia tawm koj cov ntaub ntawv kho mob.

Redisclosure notice to patient: *If the person(s) and/or organization(s) listed on the front side are not health care providers, health care clearinghouses, or health plan, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization(s) redisclose your health information.*

Lus tshaj tawm rau tus neeg tau txais cov ntaub ntawv kho mob hais txog kev qhia tawm: Tshwj tsis yog tias tau kev tso cai los ntawm Seem 146.82 hauv Wisconsin Cov Cai, txwm tsis pub koj qhia tawm tus neeg mob cov ntaub ntawv mus ntxiv yam uas tsis tau tsab ntawv sau tso cai los ntawm tus neeg uas cov ntaub ntawv hais txog nws.

Disclosure notice to recipient of patient health care records: *Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.*

Lus tshaj tawm txog kev qhia tawm rau tus neeg tau cov ntaub ntawv kho kev noj qab nyob zoo ntawm kev xav, kev quav dej cawv thiab/los sis yeeb tshuaj: Cov ntaub ntawv no tau qhia tawm rau koj los ntawm cov ntaub ntawv uas tsis pub lwm tus neeg paub uas muaj kev tiv thaiv los ntawm tsoom fwv txoj cai. Tsoom fwv cov cai (42 CFR Seem 2) txwv tsis pub koj qhia tawm cov ntaub ntawv no mus ntxiv yam uas tsis tau tsab ntawv sau tso cai los ntawm tus neeg uas cov ntaub ntawv hais txog los sis raws li tso cai los ntawm cov cai. Ib tsab ntawv tso cai dav dav qhia tawm cov ntaub ntawv kho mob los sis lwm cov ntaub ntawv mas TSIS txaus los siv rau qhov no.

Disclosure notice to recipient of mental health, alcohol and/or drug treatment records: *This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.*

Koj cov cai hais txog tsab ntawv tshaj tawm no
Your rights with respect to this authorization

- Cai tau txais tsab ntawv tso cai no ua qauv – Koj muaj cai tau txais tsab ntawv tso cai no ua qauv.
  Right to receive copy of this authorization – You have the right to receive a copy of this authorization.
- Cai tsis kam kos npe rau tsab ntawv tso cai no – Koj muaj cai tsis kam kos npe rau tsab ntawv tso cai no. Tus (Cov) neeg thiab/los sis lub (cov) koom haum uas muaj npe saud yuav muab tsis tau kev kho mob, kev them nqi, kev koom hauv ib qho kev pab them nqi kho mob los sis kev tsim nyog rau ib qho kev pab kho mob raws koj qhov kev txiav txim los kos npe los sis tsis kos npe rau tsab ntawv tso cai tshwj tsis yog hais txog:
  – kev kho mob uas muaj feem txog kev tshawb fawb
  – kev koom hauv ib qho kev pab them nqi kho mob los sis kev tsim nyog
  – nqe lus txog kev kho mob uas tsuas siv rau kev tsim cov ntaub ntawv kho mob uas muaj kev tiv thaiv rau kev qhia tawm rau sab nraud

  Right to refuse to sign this authorization – You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding:
  – *research-related treatment*
  – *health plan enrollment or eligibility*
  – *the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party*
- Cai tshem tawm qhov kev tso cai no – Koj nkag siab tias yog tias koj xav rho tawm qhov kev tso cai no, koj sau ntawv tuaj tau. Yog xav tau daim ntawv los tshem tawm qhov kev tso cai no, koj nug tau rau qhov chaw Tswj Cov Ntaub Ntawv Kho Mob (cov ntawv kho mob). Koj nkag siab tias qhov koj tshem tawm ntawd yuav siv tsis tau rau cov kev siv thiab/los sis cov kev qhia tawm txog koj cov ntaub ntawv kho mob uas tus (cov) neeg thiab/los sis lub (cov) koom haum uas muaj npe saud twb tau lawm ua ntej tau txais koj daim ntawv kom tshem tawm. Koj nkag siab tias yog tias qhov kev tso cai yog tau los ntawm qhov uas kom tau kev pab them nqi kho mob, lwm cov cai muab tus neeg yuav kev tuav pov hwm ntawd cai los tawm tsam ib qho nqi raws li hauv tsab cai (policy) los sis tus cai (policy) kiag.

  Right to withdraw this authorization – You understand that if you want to cancel this authorization, you must do so in writing. To obtain a form to cancel this authorization, you may contact the Health Information Management (medical records) department. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have made prior to the receipt of your cancellation form. You understand that if the authorization

Tsab Ntawv Tso Cai Qhia Tawm Cov Ntaub Ntawv (Txuas mus)

Tus neeg mob lub npe *Patient name*	MHN *MHN*	Hnub yug *DOB*	Muaj tsawg xyoo *Age*	Poj niam los sis txiv neej *Gender*

was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.

- Cai soj ntsuam ib daim qauv ntawm cov ntaub ntawv kho mob uas yuav siv los sis yuav qhia tawm – Koj nkag siab tias koj muaj cai los soj ntsuam los sis luam ua qauv (tej zaum yuav tau them ib tug nqi uas tsim nyog) cov ntaub ntawv kho mob uas koj tau tso cai siv los sis qhia tawm raws li tsab ntawv tso cai no. Tej zaum koj yuav npaj soj ntsuam tau koj cov ntaub ntawv kho mob los sis tau cov qauv ntawm koj cov ntawv kho mob los ntawm qhov nug qhov chaw Tswj Cov Ntaub Ntawv Kho Mob (cov ntawv kho mob).
  Right to inspect a copy of the health information to be used or disclosed – You understand that you have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form. You may arrange to inspect your health information or obtain copies of your health information by contacting the Health Information Management (medical records) department.
- Cov ntawv qhia txog qhov ntsuam xyuas HIV – Qhov qhia txog koj qhov kev soj ntsuam HIV tej zaum yuav muab qhia tawm yam uas tsis tau koj qhov kev tso cai rau cov neeg/cov koom haum uas saib tau raws li hauv Wisconsin txoj cai thiab muaj daim ntawv teev cov neeg/cov koom haum ntawd cov npe thaum thov txog.
  HIV test results – Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- Ntaub ntawv kho txoj kev noj qab nyob zoo ntawm kev xav – Koj muaj cai los soj ntsuam thiab txais ib daim qauv ntawm koj cov ntaub ntawv kho txoj kev noj qab nyob zoo ntawm kev xav raws li qhov yuav tsum tau ua hauv HFS 92.05 thiab 92.06 hauv Wisconsin Tus Cai Khiav Dej Num (Administrative Code).
  Mental health treatment records – You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

